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DISEASES OF THE SPINE AND OF THE NERVES.

16 PAGES.

CLINICS.

CLINICAL LECTURE.

Clinical Lecture on Atresia Vaginae, by
T. SPENCER WELLS, F. R. C. S., Surgeon
to Her Majesty's Household, delivered at
the Samaritan Hospital, Jan. 12th, 1870.

Gentlemen: A young woman will be
placed on the table directly; and as soon
as she is under the influence of the vapour
of bichloride of methylene, which Dr.
Junker is administering, I propose to make
an opening in the direction of the vagina,
in front of the rectum and behind the blad-
der, where there is no opening now, into a
tumour which can be felt by a finger passed
into the rectum, and which I believe to be
the uterus greatly distended by menstrual
fluid which cannot pass away owing to the
vaginal atresia.

I use the term *atresia*, rather than *occlu-
sion* or *obliteration*, because it more accu-
rately expresses the actual condition in

this and similar cases. Occlusion or
obliteration of a canal almost implies that
the canal was once open, but has been
afterwards closed. In many cases this has
actually occurred. But in others, so far as
we can ascertain, the canal never has been
open. There has been a congenital defect,
an absence of opening—*ἀ και ὁπῖς*.

I only saw this young woman yesterday
for the first time, at the request of my col-
league, Dr. Day. He had at once detected
what I believe we shall find to be the true
state of the case; although three other
medical men of considerable experience
had considered the tumour felt by the rec-
tum to be a fibroid tumour of the uterus,
which, by its pressure downwards, had oc-
cluded the vagina. I am not surprised at
this diagnosis, for the tumour felt by the
rectum is extremely hard and nodular; yet
I can detect an elastic yielding to pressure,
which, taken with the fact of the absence
of vaginal canal, and the excessive suffering

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at the menstrual periods, leaves scarcely a doubt in my mind as to the accuracy of Dr. Day's diagnosis.

Now that the patient is well under the influence of the anæsthetic, and held in the lithotomy position, I pass a sound along the urethra into the bladder, and find the bladder pushed considerably higher, and more forward than usual. With the index finger of my left hand in the rectum, I feel just beyond the sphincter a hard, round, irregular swelling depressing the anterior wall of the rectum, pushing it towards the sacrum, and extending forwards towards the pubes. The labia and nymphæ are well formed. There is no hymen, but about an inch beyond the labia, the vagina—which at the orifice appears to be well formed—ends in a mass of dense unyielding tissue, so dense that the tumour distinctly felt by the rectum cannot be felt through this septum. Keeping my finger in the rectum, pressing my thumb against this septum, and holding this long, narrow knife with its back towards the bladder, I very cautiously pass it through the closed end of the vagina into the swelling against which my finger in the rectum is pressing. The knife passes a full inch before resistance ceases, and now you see a little viscid, dark-red, treacly substance oozing down the blade of the knife. I am quite safe, therefore, in enlarging the opening by a notch on either side as I withdraw the knife; and now, on introducing this conical silver canula, you see the thickened menstrual blood passing away. It is so viscid andropy that I draw it in long cords, like glue, from the open end of the canula; and now that several ounces have come away—and pressure on the abdomen above the pubes helps it away more rapidly—I inject warm water, to which a little iodine has been added, until the whole of the dark fluid is washed away, and the iodine solution returns nearly pure. On withdrawing the canula, and passing my finger to make a little more dilatation, I feel what I believe to be the dilated uterine cavity; but there is no distinct cervix to be made out. The hard mass through which the finger passes is probably the upper portion of the vagina, contracted and blended in one indistinguishable mass with the cervix uteri.

I shall not insert any dilator, or tent, or drainage tube to-day, but the iodine injections will be repeated at intervals of six or eight hours; and, on any sign of the open-

ing closing, either a liminaria tent or a silver canula will be made use of.

These are not very common cases, and it is curious that I had to do an operation almost precisely similar to this last week on a young woman now in the hospital, and for the third or fourth time. She was sent to me by Sir Henry Thompson some two years ago, and I did what I have done to-day, evacuating some twenty ounces of fluid. For five months she remained quite well, and menstruated regularly; then the vagina closed again, and after three months I had to repeat the treatment. I followed it up by tents, but they caused a deal of pain. After four months' regular menstruation we had another closure. So this time I have kept the vagina open by a silver canula, made with flanges, which open and keep it in position. None of the operations on this patient have been followed by any febrile symptoms or much pain. We have kept her two or three days in bed as a matter of precaution, and have used the iodine injections; but she has always been able to return home almost immediately. Even now nothing like a normal uterus can be felt by the rectum, and on passing the finger along the opened vagina it enters an irregular, ill-defined cavity, which offers no distinct resemblance to the canal of the cervix or the uterine cavity. Probably the uterus had been so long distended before the vagina was first opened that it has never properly contracted, or there may be some congenital malformation of the uterus contemporary with the vaginal atresia.

In these two cases the closure of the vagina is higher up, more complete, and accompanied by a more abnormal condition of the uterus than in the class of cases most commonly met with in our out-patient rooms and in private practice. The commonest case of all is a mere adhesion of one labium to the other—the labia majora or minora, or both. Sometimes this is noticed in an infant soon after birth—often not until the child is two or three or eight or ten years old, and then a nurse or mother washing the child observes the defect. Nothing can be simpler than the treatment. By firm pressure with a thumb on either side the labia are squeezed outwards—torn apart—and a connecting filamentous medium is seen to separate, with little pain to the patient, and with scarcely a drop of blood. A great service is rendered to the girl, and the

mother is relieved of great anxiety. I once saw this condition after puberty leading to retention of the menses, and on separating the adhering labia a well-formed crescentic hymen was seen, over which the menstrual fluid freely escaped. I fancy that many of the so called cases of *imperforate hymen* are such cases of *atresia vulvæ* as I have just noticed. In early infancy or childhood vaginitis or infantile leucorrhœa is easily set up by inattention to cleanliness. The mucous membrane is blistered, and the apposed raw surfaces unite, just as they occasionally unite after labour, and have to be separated before sexual intercourse can be resumed. But we do occasionally, though rarely, see true cases of an imperforate hymeneal membrane. The membrane completely closes the orifice of the vagina, and prevents the escape of the menstrual fluid, which, retained behind, dilates the vagina, the uterine cavity, and the Fallopian tubes, possibly leading to fatal rupture, peritonitis, or hæmatocele. Sometimes, on separating the labia, the distended hymen appears as a red, tense, fluctuating cyst. But, if I may judge from my own experience, as well as from the literature of the subject, a true imperforate hymen is much less common than either a vulvar or a vaginal atresia, though more common than a true congenital absence of vagina—a very rare malformation, in which the rectum and bladder are only separated by their own walls, an instance of which may now be seen in a woman in this hospital, in Dr. Routh's ward. In this case the urethra is so widely open that it may easily be mistaken for the vagina; and it reminds me of a lady whom I saw some years ago with Dr. Farre, who had been married several years, but whose vagina was almost closed by a dense hymeneal membrane; and it was quite certain that marital intercourse had always taken place by the dilated urethra. We afterwards found that in this lady the vagina and uterus were both perfectly formed. About the same time I saw a young married lady with Dr. Farre, to whose parents a written opinion of considerable authority had been given against her marriage on the ground of malformation. As she was engaged to be married, Dr. Farre was consulted. He differed from the opinion which had been given, and, knowing that I was interested in such cases, kindly asked me to see the patient with him. When she was under the

influence of chloroform, I made a careful dissection (after a short incision along the raphe of the perineum) in front of the anus, working with a probe and a blunt silver knife, and separating the bladder and rectum from each other for some little distance until we came into a perfectly well-formed vagina and felt a normal uterus. I scarcely remember an instance in which such complete relief, to a very distressing family trouble, was so readily afforded. The patient married, and has had two children since. In another case, where marriage was stopped by an occluded vagina, I believed the cause of the occlusion to be a fatty tumour which had formed in the right recto-ischiatic space, and I removed this tumour. It weighed nearly a pound. But the removal did no good further than to admit of a more complete examination, which led to the discovery that there was congenital absence of the uterus. I obtained Dr. Farre's valuable opinion in this case, and we both certified that there was no uterus, and that marriage ought not to be permitted.

Dr. Farre kindly assisted me in the diagnosis of another case which had puzzled me excessively. Dr. Irvine, of Stanmore, brought a young woman to me with a large abdominal tumour; and on making a vaginal examination (as I thought) I could feel no uterus. I then found that my finger had passed quite easily along the urethra into the bladder, and that the vagina appeared to be absent. At least a finger in the rectum and another in the bladder appeared to be separated only by thin layers of membrane. Yet, menstruation was said to be quite regular and free from pain. At first I thought that the menstrual fluid must come away through the bladder; but on examination during menstruation we found a minute aperture behind the urethra, just in front of the anus, from whence the fluid exuded. Taking this as a guide, I made a very cautious dissection until I came into a well-formed vagina, and felt a normal cervix uteri, which could not be felt through the rectum, as it was concealed by a large fibroid tumour, which grew from the right side and posterior part of the fundus uteri. I mention these cases merely as illustrations of different forms of atresia of the vagina. In works on congenital malformations of the female genital organs, you may find other varieties described.

In conclusion, I will just say a word as to the treatment of the menstrual retention which is dependent on any of the forms of atresia of the vagina. I suppose no one can doubt that a passage for the retained fluid ought to be made, and, if possible, so kept open that subsequent retention cannot occur. We know that this cannot be done without some risk. In some cases acute pelvi-peritonitis, or pelvic cellulitis, or uterine phlebitis, with high fever, pain, and vomiting, have followed opening of the canal and evacuation of the fluid, and have ended in death. But there are numerous cases on record where death has occurred after a similar train of symptoms before any operation had been performed. The fluid secreted and retained distends the uterine cavity and the canals of the Fallopian tubes, and escapes into the peritoneal cavity, either by rupture of one of the tubes or through the open end of the canal, or in some more indirect way, it leads to a peri-uterine hæmatocele or a pelvic abscess; a Graafian vesicle matures and bursts, it is not grasped by the fimbriae of the tube, and blood is effused into the cellular tissue between the ovary and the uterus; or there is general congestion of the venous plexuses in the neighbourhood of the uterus, and one of the veins gives way. To some such danger as this any woman is daily and hourly exposed, in whom a mechanical obstruction interferes with the escape of the menstrual fluid, and I think we ought to remove the obstruction as soon as possible.

It has been supposed by some that puncture by the rectum might be safer than opening the closed vagina—that the entrance of air and consequent putrefactive changes in the fluid not completely evacuated would be prevented by the closure of the sphincter ani; and several successful cases have been recorded where this practice has been adopted. I have before now expressed my opposition to this view. I cannot see that the intestinal gases, which would enter from the rectum into the emptied cavity, can be less injurious than atmospheric air. Of the two I should prefer the air without the fecal gas. And then the patient is left with a closed vagina—she is simply relieved for a time from the consequences of menstrual retention; whereas if you open the closed vagina you afford the same immediate relief, and render an ad-

ditional service which may be a permanent relief. By a little care the opened canal may be kept open; and, if it should close through want of care, it may be reopened. It cannot be done without some risk, but the risk of leaving the patient alone is vastly greater.—*Med. Times and Gaz.*, Jan. 22, 1870.

—
Clinical Lecture on Injuries of the Head, by JAMES PAGET, F.R.S.—This subject was illustrated by two cases of injury of the head which have lately been under Mr. Paget's care.

In the first case, a boy, aged 11 years, met with an accident which caused a compound, slightly depressed, and starred fracture of his left parietal bone. He was stunned for some hours, then vomited, and the next day sat up in bed and answered questions. He had, then, no symptoms of compression, and for that reason he was not trephined. He went on well for twelve days, but, on the thirteenth, he was found to be flushed, and to have a rapid pulse, quick breathing, and a temperature of 103.2; two days later, he was found to have signs of double pneumonia, after which he gradually sank, and died two months after the accident. At the post-mortem examination both pleuræ were found filled with purulent fluid. The dura matter corresponding to the depressed portion of the bone was inflamed and adherent to the bone; there was no inflammation of the arachnoid, but, in the substance of the hemisphere immediately beneath the depressed fragment of bone, was a small abscess or slough of brain-substance, about as large as a sixpence in area.

In alluding to this case, Mr. Paget remarked that compound fractures of the skull in young persons are usually recovered from without interference when there are no signs of compression, but considered it possible that in this patient, trephining, although contrary to his usual practice in such cases, might have been beneficial. Mr. Paget thought, however, that it was very doubtful whether the elevation of the depressed fragment would have put the lad in any better position with regard to pyæmia than leaving it alone. In referring to the treatment of the secondary inflammation in cases like this, Mr. Paget said that he was not aware of any rule which could be laid down on

the subject; secondary trephining in the present case would clearly have been absurd.

On the question of trephining for injuries of the head, Mr. Paget said he did not consider that large enough statistics of successes and failures had yet been collected to admit of our forming rules which shall be constantly applicable. Mr. Paget gave the following provisional laws as, in his opinion, expressing the results of our present knowledge.

1. *Simple Fractures of the Skull.*—*a.* When there are no signs of compression, and no depression, leave the patient alone. *b.* Without depression, but with signs of compression (i.e., abiding insensibility), we may interfere if we can diagnose the seat of fracture. *c.* When there is depression, but no sign of compression, it is best to do nothing if the patient be young; if old, however, there is some doubt about the propriety of non-interference. *d.* When there is depression and compression, we must operate.

2. *Compound Fractures.*—*a.* When there is no depression, and no sign of compression, as a rule—especially in young patients—do nothing. *b.* When there is no depression, but there are signs of compression, it is right to interfere. *c.* With depression, but no signs of compression, it is best not to interfere when the patient is young; but probably it is right to operate on an old person. *d.* With depression and abiding insensibility, operate.

The second patient to whom Mr. Paget referred was a man who was admitted for compound fracture of the lower jaw and of the nasal bones, lacerations, and contusions. He was supposed, from appearance after the accident, to be drunk. The next day he was quite sensible, but restless; on the fourth or fifth day he became partly comatose; his breathing was very quick, and his face became much swollen and erysipelatous. Mr. Paget diagnosed some secondary erysipelatous inflammation in the cranium. The man continued to get worse, and died. At the post-mortem examination, a fracture was found extending through the nasal bones, superior and inferior maxillæ, ethmoid, sphenoid and basilar process of the occipital bone, into the foramen magnum. Purolymp in abundance lined the dura mater, and pus was found in the meshes

of the pia mater, especially along the lines of the larger arteries. Mr. Paget called attention to the disproportion between the immediate symptoms in this case and the extent of the injury, and remarked that fractures of the base are frequently unattended by signs of compression. Mr. Paget also noticed, in this connection, that fractures of the anterior part of the skull are far less fatal than those of the posterior part.

Mr. Paget alluded, in connection with these two cases, to the nature of the secondary inflammation, and insisted on the importance of drawing a broad line in practice, between an inflammation which results directly from an injury and one which follows it at an interval of several days; the former being *ethenic*, the latter *aethenic* and allied to the erysipelatous inflammations.

This led to the subject of erysipelas. Mr. Paget referred to a case now under his care, which illustrated the tendency of erysipelas to shift about from one part or organ to another. The disease, Mr. Paget remarked, is well known to shift from one part of the surface to another, and from the surface to a deeper organ, but it very rarely shifts from a deep structure to one more superficial. Mr. Paget mentioned the following case as an illustration of this rare condition. The patient (a little girl) was admitted on account of a severe burn. She became affected with delirium, fever, and restlessness, and these symptoms led Mr. Paget to diagnose an inflammation of the brain membranes. When she had been in this state for three days, however, erysipelas appeared on the scalp, and, simultaneously, the delirium was relieved, showing, in Mr. Paget's opinion, a translation of the erysipelatous inflammation from her brain membranes to her scalp.

In connection with the recent occurrence of some cases of erysipelas in his wards, Mr. Paget made some remarks on the extreme importance of cleanliness in the treatment of this disease, especially with the view of preventing infection. Mr. Paget said that, although several cases of erysipelas had been in the neighbourhood of patients on whom operations had lately been performed, and had even originated in the wards, yet no single case of propagation of the disease had occurred; and, that he believed this result to be mainly due to scrupulous care in keeping

everything about the patients and in the wards very clean, dry, and well ventilated.—*Brit. Med. Journ.*, Feb. 5, 1870.

HOSPITAL NOTES AND GLEANINGS.

Absorption of Pleuritic Effusion by Abstinence from Fluids.—Dr. GLAUERT has recently published in the *Berliner Klinische Wochenschrift* an interesting case observed in Professor Von Niemeyer's Clinic at Tübingen, in which rapid absorption of pleuritic effusion was obtained by depriving the patient of water and fluid nutriment. He observes that the ordinary treatment of pleuritic effusion, which remains stationary after the subsidence of febrile action, is not satisfactory, and that it is desirable to abstain from thoracentesis except in those cases where other means have failed. Diuretics or purgatives are of little use in the affection; but Niemeyer has repeatedly shown in his Clinic the great utility of energetic diaphoresis in the various forms of dropsy. That by its agency a larger quantity of water can be abstracted from the body than gains admission to it has been repeatedly shown by careful weighings; and in all probability hot baths, followed by woollen coverings, as recommended by Ziemssen in other forms of dropsy, would prove useful in pleuritic effusion. But there is another mode by which the necessary inspissation of the blood and consequent energetic absorption of fluid may be obtained, and that consists in limitation of the amount of liquid taken. Experience proves that, in persons exposed to absolute hunger and thirst, the excretion of water by the kidneys, as well as the insensible perspiration, although diminished, do not cease; and that a very considerable diminution of fluid may be borne without danger is shown by its irrational employment in the treatment of various diseases in the bread of Scrothcure.

The case now under consideration occurred in the person of a robust man, aged 42, who took cold November 5, 1869, and came to the Clinic on the 20th, the subject of pleuritic effusion on the right side reaching to the third intercostal space, the febrile action having subsided. Being very anxious to get well speedily, he readily consented to abstain from all fluid nourishment, and to live on bread and slightly salted sausage. On the first and second days, however, he

complained sadly of this diet, and was, on account of the dryness of his mouth, able to eat hardly any of the bread or sausage. He asked for a slice of apple now and then, and licked the ironwork of the window. During the first twenty-four hours of the treatment the entire amount of urine was 550 cubic centimetres, containing 4.4 per cent. of urea. Next day this had diminished to 450 cubic centimetres, with 6 per cent. of urea, and the patient found that the oppression of breathing had ceased, and that he could ascend stairs much easier. Half a pint of wine and a cup of coffee were allowed. On the 23d the urine had diminished to 420 cubic centimetres, with 6.8 per cent. of urea, and the effusion had sunk to below the nipple. During the next three days (24th—26th) he took only half a pint of wine daily, the urine averaging 417 cubic centimetres, with 6.6 per cent. of urea. By the 27th there remained only a little dullness just above the liver, and the patient could run up stairs rapidly with ease. Next day he was dismissed cured, having an excellent appetite.

This is a remarkable example of the rapid removal of recent effusion, but in another case, in which the effusion had existed for months, and which was similarly treated, the effect was only temporary. In this case a daily diminution of weight by a pound or two occurred, together with a spare secretion of urine, and the effusion and all the symptoms diminished; but in a few days afterwards the former weight was recovered, and the effusion again increased.—*Med. Times and Gaz.*, March 26, 1870.

Strangulated Hernia.—Six cases of this were under the care of Mr. MAUNDER in the London Hospital, at one time in February last, five having been submitted to operation, and one had been reduced by taxis under chloroform. With regard to chloroform as an aid to taxis, Mr. Maunders has observed that just when the breathing becomes stertorous, reduction is effected. Such was the case in the instance of W. B., aged 53, the subject of strangulated inguinal hernia. The anæsthetic had been previously administered, but its influence had not been fully exercised, and taxis had failed.

The danger of administering opium during strangulation was well illustrated in a female, E. M., 66 years of age, with

strangulated femoral rupture. Symptoms had existed some twenty hours, and the stomach could not retain food. At this period half a grain of morphia was injected subcutaneously. All pain in the abdomen and tumour subsided, and the irritability of the stomach was so far allayed, that the patient was able to take and to retain half a basin of beef-tea, although strangulation persisted and required operation. As a rule, opium should only be given in the very early stage of strangulation, and upon the understanding that if reduction be not effected within four hours of its administration, herniotomy is to be performed. When strangulation is relieved, opium is most valuable, in order to keep the bowel at rest, that it may have time to recover from the effects of constriction.—*Med. Times and Gaz.*, March 19th, 1870.

Sympathetic Ophthalmia; Division of Ciliary Nerves; Temporary Relief; Subsequent Extirpation.—T. B., a boiler-maker, aged 27 years, received an injury of the left eye, on January 20th, 1869. He was hammering a rivet, and a piece "flew up into, and cut, his eye, and rebounded." He thinks that no part of the piece of iron remained in the eye.

When seen, on April 8th, 1869, the left eye was intensely inflamed and painful. The pupil was distorted and displaced downwards, and a cataract was visible through it. The wound was evidently at the lower and inner part of the corneo-sclerotic junction, and the iris was drawn downwards into the cicatrix. The tension was very much below the normal standard. The eyeball was markedly tender at the upper ciliary region. There was a slight perception of moving objects held below the eye. Ever since the accident he had suffered from pain, and photophobia, and had consequently been unable to work; and there was circumorbital pain around the right eye. The photophobia affected the right eye as well as, or perhaps more than, the left.

April 16th. Some relief had followed the application of an opiate ointment to the left brow and temple, and the administration of a tonic mixture; but there was still sympathetic irritation, and the tenderness in the upper ciliary region remained. The case seemed one to which the operation proposed by Dr. E. Meyer, of division of

the ciliary nerves, was well adapted; because the tenderness was distinctly limited to a particular part of the injured globe, and it seemed very possible that the nerves of this tender spot might be the offending filaments, the division of which might cut off the communication between the morbid and healthy eyes. On April 16th, therefore, the sclerotic, choroid, and ciliary nerves were divided immediately behind the insertion of the superior rectus, by the operation of Dr. E. Meyer. The operation, which must have been exceedingly painful, was performed without giving chloroform; the patient, however, scarcely flinching, and making scarcely any signs of suffering.

The relief following this operation lasted till May 7th, or later; all pain and photophobia having ceased within a few days after the division of the nerves. The eyeball, however, remained injected, and soon became much more so; and on June 1st it was so painful and inflamed, and the sympathetic irritation had so completely returned, that the patient submitted to extirpation of the injured eye. On removal, no foreign body was found in the eye; but a fleshy mass growing from the sight of the wound, and extending into the vitreous space.

Since this last operation the recovery was uninterrupted, and on September 10th he presented himself with a well-fitted artificial eye, and declared that he could now do his work as well as ever. He had, however, been obliged to learn to use his hammer as a right-handed man, having been before left-handed. This had caused him some delay in returning to full employment, which he would have commenced at an earlier period, but for this circumstance.

REMARKS.—The case gives a good prospect of successful results in some cases of sympathetic ophthalmia after division of the ciliary nerves. In this case, the patient scarcely allowed his eye to have rest long enough after the operation; but, being anxious to return to his employment, brought on a fresh attack of inflammation and sympathetic irritation. How far this temporary relief may have been due to allowing a drain from the vitreous humour through the sclerotic wound, it is difficult to say; but the fact of the return of the inflammation is quite consistent with the view that the sclerotic may have closed up at this

time, and the beneficial drain from the interior of the eye have been so cut off.—*Brit. Med. Journ.*, Oct. 16, 1869.

Thrombosis of the Middle Cerebral Artery; White Softening of the Brain.—

For many years the accidental plugging of an artery by a piece of fibrin detached from the valves of the heart has been recognized as a cause of white softening in that part of the brain which was supplied by that vessel. A similar result, too, is obtained when molecular particles are carried from a diseased aorta into the cerebral capillaries. Thrombosis of an artery, or the formation of a clot at the point of obstruction, is a much rarer cause; but of this kind two cases have recently been met with in the hospital. In each case the vessels at the base of the brain were very atheromatous, and at some parts their calibre was greatly impaired. At the spot where the internal carotid artery divides into the anterior and middle cerebral arteries, a firm clot of fibrin was found plugging up the middle cerebral completely. In each case the vessels were much roughened by atheromatous deposit at this point; and the altered surface would thus the more readily allow of fibrin being whipped from the blood as it flowed along. The left side of the heart and the large vessels were quite healthy: and there can be no doubt that the plug of fibrin was formed at the spot, and not carried from a distant point. But whatever may be the cause of the obstruction, the cutting off of the blood-supply results in atrophy, or white softening of the parts previously supplied.

CASE 1.—Eliza D—, aged sixty, was admitted, under the care of Dr. Beale, into Twining ward, on Dec. 16th, 1869. She had always been temperate, and enjoyed excellent health. Towards the end of November, 1869, she suddenly lost the use of her right arm and leg; but in a fortnight she was quite well again. Three weeks before admission she had complete loss of power in the left leg and arm, and partially of the left side of the face; the pupils were natural, the eyes did not deviate, and there was no arcus senilis. At first she was conscious, and could give an account of her attack; but gradually she passed into a comatose state, and remained so several days before she died. The paralyzed side became very rigid, and was so the whole time she was in the ward. This rigidity came

on soon after the attack. The urine was passed unconsciously, and contained towards the end a trace of albumen. Death occurred a month after admission into the hospital.

A post-mortem examination was made about thirty hours after death. On opening the skull, the dura mater was found healthy; the large vessels at the base of the brain were very atheromatous, and their calibre thus somewhat impaired. The middle cerebral artery on the right side was blocked completely by a plug of fibrin, which was firmly adherent to the wall of the vessel; at this spot the vessel was very atheromatous, and the fibrin seems to have been deposited upon the roughened inner coat of the vessel. Beyond this obstruction the smaller branches were full of dark fluid blood, as the collateral circulation was established. The right hemisphere was in a state of white softening, and broke down under a gentle stream of water; there was no hemorrhage anywhere. The left side of the brain appeared healthy, and no trace could be found of any former lesion. The heart was healthy, and neither the valves nor the large vessels had undergone any morbid change. The blood was everywhere fluid, and all the organs much congested.

The cause of the congestion of the tissues seemed to be that, in consequence of the brain lesion, the due supply of nerve-force to the smaller arteries was interfered with; thus stagnation in the capillaries resulted. The blood was properly aerated in its passage through the lungs, and so venous blood was found in the arteries, and was the cause of the full pulse which was noticed during life. To the same cause may be ascribed the torpor of the bowels. No motions were passed after her admission, although various purgatives and enemata were administered. After death a considerable quantity of hard scybala was found in the intestines.

CASE 2.—Sarah E. K—, aged fifty, was admitted under Dr. Johnson, in Twining ward, on December 10th, 1869. She was a temperate woman, and had had no serious illness at any time. On December 7th she fell down insensible, and it was noticed that she had lost the use of her right arm and leg; the face did not seem paralyzed, nor did the eyes deviate; the pupils were natural and acted equally

to light. While in the ward she was in a semi-comatose state, and not to be roused without difficulty. Her right side was quite rigid, but less so a short time before death. She passed her motions and urine involuntarily; there was no albumen. She died nine days after the attack.

At the post-mortem examination, which was made twenty-four hours after death, the vessels at the base of the brain were found very atheromatous, more especially the basilar and carotid arteries. On the left side of the brain white softening had taken place for a space of two inches in circumference, on the outer side of the corpus striatum and optic thalamus; the brain-substance was quite diffuent here, but in the rest of the organ was healthy. The left middle cerebral artery was completely plugged by a firm plug of fibrin, which had coagulated on the roughened surface of the artery, for the vessel was atheromatous at this spot. The heart and aorta were healthy, and it was clear that in this case, as in the preceding one, the obstruction was due to thrombosis, and not to embolism.—*Lancet*, March 19, 1870.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Intermittent Fever complicated with Rheumatism. By B. E. DODSON, M.D., Alden, Iowa.—Nothing is more common in marshy districts than to find intermittents complicated with rheumatism, and *vice versa*, and to their successful treatment a true diagnosis is very essential. During 1864 and 1865, in the fortifications about Washington, this complication was of every day occurrence, and those surgeons that relied on "quinia, Fowler's solution, mass. hydr. &c.," generally lost their patients, and wondered that quinia would not cure the ague.

Since 1850, I have treated all kinds of rheumatism with iodide of potassium and ipecac, paying no attention to whether the case is recent, or of long standing, inflammatory or chronic, of "the blood" or "of the nerves," &c., and I have never found a case correctly diagnosed that did not yield satisfactorily.

I give from one-half ʒ to ʒ doses every four hours, alternated with from 3 to 5 grs. ipecac (the patient kept warm and in bed)

for a full grown man—smaller men, women, and children, according to size and physical development—continued from five to ten days always cures. I have given as high as ʒj of the potassium in twenty-four hours to large men, of full habit, in acute attacks. The only unpleasant result is a little difficulty in swallowing for a time, which soon subsides on stopping the medicine.

University of Pennsylvania, Medical Department.—Dr. D. HAYES AGNEW has been appointed Professor of Clinical and Demonstrative Surgery, and H. LENOX HODEX, M.D., Demonstrator of Anatomy, in this school. Both appointments are regarded as excellent.

List of Medical Graduates in 1870 (continued from p. 56, April No.)

College of Physicians and Surgeons (New York)	74
Albany (N. Y.) Medical College	23
Medical Dept. University of Louisville	92
Indiana Medical College	20
Starling Medical College	24
Med. Dept. University of Nashville	58
St. Louis Medical College	43
Missouri Medical College	29
St. Louis College of Physicians and Surgeons	2
New Orleans School of Medicine	27
Med. Dept. of Willamette University	7

Medical College of the State of South Carolina.—Several changes have been made in Faculty of this School. Prof. E. Geddings has resigned the chair of the Institutes and Practice of Medicine, and has been elected Emeritus Professor of that branch, and also Professor of Clinical Medicine—a chair recently created. We are glad that the institution will thus retain the services of our old and esteemed friend, Dr. Geddings, who is one of the most erudite, experienced, and skilful practitioners in our country. Other changes have been made in the school.

The Faculty, as at present constituted, is as follows:—

E. Holbrook, M. D., Emeritus Professor of Anatomy.

E. Geddings, M. D., Emeritus Professor of the Institutes and Practice of Medicine, and Professor of Clinical Medicine.

R. A. Kinloch, M. D., Professor of Surgery.

F. M. Robertson, M. D., Professor of Obstetrics and Diseases of Women and Children.

J. P. Chazal, M. D., Professor of General Pathology, Pathological Anatomy and Hygiene.

Middleton Michel, M. D., Professor of Physiology.

Geo. E. Trescot, M. D., Professor of Materia Medica and Therapeutics.

C. U. Shepard, Jr., M. D., Professor of Chemistry.

J. F. M. Geddings, M. D., Professor of the Institutes and Practice of Medicine.

F. L. Parker, M. D., Professor of Anatomy.

Albany Medical College.—Dr. Thomas C. Durant, of New York, a graduate of the college, and an early student of Drs. March and Armsby, has given \$15,000 to endow the "March Professorship."

Drs. E. R. Peaslee and Meredith Clymer, of New York, and Dr. Wm. P. Seymour, of Troy, have accepted chairs in the faculty of this college.

Ophthalmological Society of Philadelphia.—A society has recently been organized in Philadelphia under the above title, and the following gentlemen were chosen officers for the ensuing year:—

President, Dr. Isaac Hays.

Vice-President, Dr. E. Hartshorne and Dr. T. G. Morton.

Treasurer, Dr. W. Hunt.

Secretary, Dr. W. F. Norris.

FOREIGN INTELLIGENCE.

Deaths from Chloroform.—A young woman went to Dr. Millar's Surgery at Acrington, on March 19, 1870, to have some teeth extracted. Chloroform was administered and after pulling out the third tooth, Dr. M., observed that the patient was dying, and life was soon extinct. She had had chloroform a week before, but it did not take effect.—Brit. Med. Journ. April 2, 1870.

A married lady, æt. 36, called at the office of Mr. Rice, in Great Barrington, Mass., Feb. 12, 1870, to have twelve teeth extracted, and wished to take chloroform, though both Mr. R., and her husband tried to dissuade her. Dr. W. H. Parks gave the chloroform by pouring a small quantity

upon a napkin, and held a little distance from the face, so as not to interrupt a sufficient supply of atmospheric air. She passed under its influence quite easily, and did not take as much chloroform to produce insensibility as in many cases. She was made partially insensible by the extraction of the first four teeth; a little more chloroform was given, and so on, until all were extracted. Nothing unusual occurred until after the operation. While in the act of retching or vomiting, she seemed to strangle, and suddenly expired. Dr. Parks was supporting her head at the time, with his finger pressing upon the temporal artery, and the first intimation of danger was the sudden cessation of pulsation, and in a moment she ceased to breathe. She was immediately placed in a horizontal position, and artificial respiration kept up for three-quarters of an hour, after which time, seeing the hopelessness of the case, further efforts at resuscitation were abandoned.—Dental Cosmos, April, 1870.

Cubebs in Diphtheria.—In a recent number of the Gazette des Hôpitaux M. VASLIN gives some account of the treatment of diphtheria by means of cubebs, introduced some time since by M. Trideau, and especially employed by M. Bergeron, of the St. Eugénie Hospital. This gentleman has already communicated several cases to the Société des Hôpitaux, telling in favour of this agent; and in the present paper M. Vaslin, his interne, gives the results as observed in the St. Eugénie during 1869. During this year 43 cases of diphtheria (cases of croup and diphtheria seem to be confounded together by the French Practitioners), 8 being examples of angina and 34 of croup. Of the 8 anginas, 7 recovered, the other dying of consecutive diphtheritic paralysis. The pharyngeal diphtheritis was primary in almost all these cases, the false membranes existing chiefly on the tonsils. The general symptoms were limited to mild febrile reaction, except in two cases, when temporary sub-delirium was present. The sole medicine employed was a saccharate of cubebs, twenty grammes being administered during the day in divided doses, no local treatment being resorted to. The false membranes were gradually dissolved, the duration of the disease not exceeding ten days.—Med. Times and Gaz., March 19th, 1870.

Tetanus—Administration of Chloral—Recovery.—M. Wurtz read to the Imperial Academy of Sciences recently a note from M. VERNEUIL, in which he relates a case of tetanus cured by the administration of chloral. M. NELATON very justly remarked that too much importance ought not to be attached to a single case of tetanus cured after the employment of a new medicine. A multitude of medicines have succeeded once or twice in apparently curing tetanus but invariably failed subsequently, proving that the cures were not the effect of the medicine.

Ligature of Internal Iliac Artery.—The operation of tying the internal iliac artery has been successfully performed by Professor Gallozzi. It was rendered necessary owing to a diffused traumatic aneurism resulting from a stab of a poignard in the superior and interior margin of the right gluteal region—the patient, a young man, aged 22. Recovery was satisfactory, but was much retarded by the occurrence of an immense abscess occasioned by the unabsorbed débris of the aneurismal sac.—*Med. Times and Gaz.*, April 9, 1870.

Subperiosteal Excision of Elbow-Joint; Reproduction of the Bones Complete.—The correspondent of the *Med. Times and Gaz.* (see No for March 19, 1870), during a recent visit to the wards of M. Ollier, at the Hotel Dieu, Lyons, found a most interesting and instructive set of cases, all kinds of bone diseases being amply represented. With regard to the subperiosteal excisions, for which this surgeon is so justly renowned, we were shown one of the elbow-joint in a man of 47 years of age, a very bad subject for such an operation, on account of his age and general unhealthy condition, and yet we were able to observe that the reproduction of the bones was very complete, and that active extension did exist to a slight extent, though the operation had only been performed about three months before. In another case of the same operation, practised on a young girl, the reproduction was astonishingly perfect, and had it not been for the cicatrix the most practised eye could hardly have detected, on seeing the elbows placed in extreme flexion, any difference between the contours of the two limbs. All the movements were also quite perfect, the only fault noticeable being that the arm could

not be extended absolutely straight, as the new olecranon seemed to meet with some opposition; this, however, would doubtless be remedied by time and the continued use of the limb. We were fortunate enough to witness the dissection of a reproduced elbow-joint, the first that Mr. Ollier has had the opportunity of examining, because, as he significantly said to us, "all my other cases are alive." It was that of a young man who had died of phthisis fifteen months after the operation of excision. We can only say that we could have wished that all who are sceptical as to the real reproduction of bones in their original forms and positions after these subperiosteal operations might have been there to have seen for themselves.

Modification of Operation for Disarticulation of Shoulder-joint.—M. VERNEUIL has introduced an excellent modification of Larrey's procede en raquette for the disarticulation at the shoulder-joint, by means of which hemorrhage is completely guarded against, and which permits, if necessary, to operate without any assistance—a great desideratum to the military surgeon.

The two cases in which I have seen M. Verneuil execute his operation were both for accidents, and where, on account of the anæmic condition of the patients, it was of the greatest importance to avoid any further loss of blood.

In Larrey's process the patient is made to sit up in bed—already a great inconvenience because of the danger of syncope in case chloroform has been administered—and an aid is required to compress the artery in the interior flap the moment the surgeon is about to finish its section. That this latter part of the operation is by no means an easy one must be acknowledged by all surgeons, especially military surgeons, who are sometimes necessitated to call in the aid of persons unacquainted with the duty assigned to them. But even with tolerably intelligent aids it may happen that the axillary artery is not properly grasped, and a serious hemorrhage is the consequence. I know of an instance which happened in the trenches before Sebastopol, where a French surgeon, about to perform this operation by candle-light, was left in the dark because the aid failed to grasp the artery as he was finishing the anterior flap, and the jet of blood put out the candle. It

is unnecessary, I suppose, to say what became of the patient in this case.

M. Verneuil's operation is as follows:—

The patient placed upon his back near the edge of the bed, the point of the knife—very much like in Larrey's process—is introduced a little below and inside the acromion,¹ and carried in a vertical direction downwards a distance of 2½ inches, cutting through the deltoid to the bone. An anterior flap is now traced with the blade of the bistoury, beginning a little below the superior extremity of the first incision, and following in an oblique direction down and inwards until arrived at the inferior limit of the axilla on the arm. The posterior flap is traced in a similar manner upon the posterior aspect of the shoulder, or may also be made by continuing the incision for the anterior flap out and upwards to the first starting point. Thus far nothing more than the skin has been incised. The muscles in the anterior flap are then divided by successively cutting through the deltoid, the pectoralis major, beneath which lies the long tendon of the biceps, and the coracobrachialis. This brings to view the vasculo-nervous fasciculus of the axillary vessels and nerves. After dissecting the flap upwards, a needle of Deschamps is passed beneath the axillary artery and vein above the point of origin of the anterior circumflex and inferior scapular arteries. The completion of the anterior and the section of the posterior flap, together with the disarticulation, can now be effected with ease and without assistance. I need not tell you that a bringing together of the flaps is not even thought of. I have had occasion to observe in former letters that our Paris surgeons never attempt union by first intention. The wound is stuffed with lint dipped into alcohol.

The ligation of the vein is a good practice. The proximity to the brachio-cephalic trunk, and the possibility of an insufficiency of the valves in these vessels exposed to the danger of the introduction of air. M. Verneuil is also in the habit of resecting the nerves of the brachial plexus as high up in the axilla as possible. In his first operation, neglecting to take this precaution, peripheral neuromata developed themselves

in the stump, forming little, hard, and very painful tumours which had to be removed some time later. I may mention en passant that, out of seven disarticulations at the shoulder, performed by M. Verneuil in the Lariboisiere Hospital for injury, all have been successful. With the same operation for pathological causes, the results have been altogether different. The modifications and advantages of this over Larrey's process consist in (1) the position of the patient; (2) hemorrhage impossible; (3) no aid required; (4) ligation of the vein; (5) resection of the nerves.—*Med. Times and Gaz.*, April 9, 1870.

Treatment of Diseases of the Knee-Joint. By THOMAS BRYANT, Assist. Surg. Guy's Hospital.—In the treatment of all cases of diseases of the knee-joint, or, indeed, of any joint, there is one question which naturally arises in the surgeon's mind, and that is as to the competency of natural processes to effect a cure. Should this question be answered in the negative, either by the judgment of the surgeon or the progress of the case, another equally important question has to be decided which has direct reference to excision of the joint or amputation of the limb, for I must assume for the present that neither of these operations would be entertained until either the circumstances of the case had fairly demonstrated that nature was incompetent to conduct it to a successful issue, even though guided skilfully by art, or that some operation was demanded to save life.

All other measures than those named—excision and amputation, must be looked upon as subsidiary to the one great object of securing a natural cure; the use of splints, division of tendons, and incision into joints tending towards this desirable end, and being of value only so far as they conduce to that one great object.

In examples of chronic or subacute synovitis no operation is needed. Such cases, as a rule, do well under surgical treatment. Rest of the limb in a horizontal posture, counter-irritation by means of blisters, and the iodide of potassium internally are generally amply sufficient to effect a cure; while pressure by well-applied strapping, after all signs of inflammation have gone and the products of inflammation alone remain, is of great value.

In traumatic cases ice applied locally is

¹ In practising this incision inside to the acromion between it and the coracoid process, the joint is less covered by the acromial vault, and the capsular ligament more easily opened.

of inestimable use, and that, with complete immobility of the affected limb, is, in the majority of cases, all that is required. When the pain is severe, an opiate should be given; or, which is better, a subcutaneous injection of a quarter or half a grain of morphia should be used.

In acute suppurative synovitis of a joint following a wound, a free incision into the joint is probably the best practice. The remedy, it is true, is a severe one when applied to the knee, but it is applied to relieve a condition which is fraught with peril. It has been attended with good success, and may be practised.

Under other and more severe circumstances, immediate amputation may be called for, as in the following case:—

CASE 43.—Severe Laceration of Thigh into Knee-Joint—Amputation six hours after the Accident—Pus in Joint—Highly Injected Synovial Membrane.

David B., aged 6, was admitted into Guy's under my care on July 5, 1862, with a severe laceration of his left thigh and knee-joint from the passage of a wheel of a loaded omnibus over the part. Nothing but amputation could be entertained, and, six hours after the accident, the operation was performed. A good recovery followed.

On examining the knee-joint directly afterwards, the synovial membrane was seen to be intensely injected all over, down to the margins of the articular cartilages. Pus was also found in the joint, about half an ounce. This was examined microscopically. The rapid injection of the synovial membrane and formation of pus is of great interest.

Mr. Maunder, within the last year or so, has reintroduced a practice which had been formerly employed with some effect—that of ligaturing the femoral artery in cases of suppurative synovitis, whether the result of a wound or of some other cause. The case for which he suggested the practice made a good recovery. The acuteness of the local symptoms soon subsided after the operation, and all pain ceased. Suppuration likewise rapidly disappeared, and recovery took place, although with a stiff joint. This result was eminently satisfactory, and it is hardly fair not to attribute it in a measure to the treatment which was employed. Such a practice, however, should be only thought of when acute suppuration is threatening, and consequently the integrity

of the joint is endangered. It might be practised before the necessity of opening the joint has appeared, and under such circumstances it seems capable of preventing it; for the sudden cutting off of the supply of blood to an inflamed part may fairly be expected to check inflammatory action, and to starve the disease, in the same way as it has been proved to do in elephas.

In acute synovitis the result of an abscess or a sequestrum making its way from the bone into the joint, or from the discharge of an abscess the product of a suppurating synovial pulpy disease, other treatment will be required; for such a complication is clearly, under these circumstances, only a result of another disease, and is not the disease itself—it is an effect and not a cause. The original cause of the synovitis must be treated if success is to follow any practice. This part will, however, receive attention as we progress.

In the pulpy synovial disease of the knee-joint uncomplicated with suppuration, the limb must be immovably fixed on a splint from the very first; fomentations should likewise be employed and tonics given. Blisters in this affection are not apparently of much use; moxas and setons are painful applications, and have no definite value. I never use them.

When the pulpy membrane breaks down and suppuration appears, the abscess being outside the joint, it should always be opened; when it has discharged itself into the joint and suppuration of the joint follows, a free incision into the articulation is doubtless the best practice.

When this treatment has failed or seems inapplicable, the question of amputation or excision will have to be entertained—that is, when it is clear a recovery with a movable or even a stiff joint is beyond hope, and when the general powers of the patient are clearly yielding to the severity of the local disease.—*Med. Times and Gazette*, April 2, 1870.

Holt's Operation for Stricture.—Mr. HOLMES exhibited to the Pathological Society (London), a urethra, in which Holt's operation for stricture had been performed. He said there was a difference of opinion as to what it is that gives way—the mucous membrane or the submucous tissue. The patient, a man nearly 60, had long had stricture, and had been subjected to a great

variety of treatment. He had been operated on by Holt's method in 1861. When seen he had retention, and a catheter was passed, but had to be removed, as it gave rise to intense irritation. The stricture was ruptured. He had rigors the same night. No. 10 catheter was passed a day or two after, but rigors still continued. Two small swellings appeared at the site of the two strictures, but they contained no pus. Gradually he became worse, vomiting ensued, and pyæmia with secondary deposits followed. After death it was found that at both strictures the mucous membrane was lacerated, most so at the posterior one. Such lacerations imply the risk of infiltration.

Mr. NUNN was convinced that Holt's operation was too much used. He thought the effect of syphilis on stricture was too much overlooked. It tends to make them recalcitrant.

The PRESIDENT asked if the second operation afforded a fair test.

Mr. HOLMES said the former operation was so long antecedent that all its effects must have passed away. Once before he had done the operation a second time.

Mr. SIDNEY JONES thought the case hardly constituted a fair test.

Mr. HÜLKE said the question whether the mucous membrane suffers or not depends on the closeness of its connections with the subjacent tissue. That it was often ruptured was proved by the bleeding.

Mr. J. D. HILL had one patient who died of pyæmia. — *Med. Times and Gaz.*, March 26th, 1870.

Cutaneous Absorption.—M. BREMOND, of Vincennes, in a lecture delivered at a late séance of the Academy of Medicine, states that he believes he has irrefragably proved the occurrence of absorption by the skin of a medicinal substance, even when this is not volatile, as in the case of iodide of potassium. In a first series of experiments he exposed the skin to the action of a vapour bath charged with the salt, gradually raised to a temperature of 113° F., for half an hour. Two hours afterwards iodide of potassium was observed in the urine, though it could only have entered by the skin. In a second series of experiments he found that no absorption ordinarily occurs unless the temperature of the vapour bath exceed the normal heat of the body by at least one or two

degrees, and the exposure have lasted for at least half a minute. Whilst in a third series he states, as the result he has obtained, that even at 95° F. absorption may occur, provided the body have previously been exposed to the action of a vapour bath, and afterwards vigorously soaped and rubbed, by which means all the oily material is removed. These experiments explain the different results that have been obtained by various observers. — *Lancet*, April 2, 1870.

Methylic Ether as a General Anæsthetic.

—Dr. RICHARDSON made a communication at the last meeting of the Medical Society — Mr. Gay, the newly-elected President, in the chair—on methylic ether as a rapidly acting general anæsthetic. The methylic ether is a gas, but it is absorbed in very large quantities by absolute ethylic ether, and in the fluid the methylic ether is held with fair stability. The ether is inhaled from a simple mouth-piece, and anæsthesia, sufficiently deep for a small operation, is induced, in some cases, within the minute. Neither symptoms of asphyxia nor of faintness have yet been observed; and one peculiar part of the phenomena of the anæsthesia is, that the operation, as of tooth-extraction, may be conducted painlessly, while the patient is capable of carrying out what seem to be perfectly conscious acts. During the past week several painless extractions of teeth have been performed under the influence of the ether, recovery from its effects being almost immediate, and unattended by vomiting or other disagreeable symptoms. — *Brit. Med. Journ.*, March 19th, 1870.

Possible duration of Pregnancy.—In the course of an action for damages for the seduction of a young woman, the question of the possibly protracted duration of gestation was raised. The alleged father had had no access to the mother of the child later than 301 days before its birth, and he naturally disputed his liability. Dr. Tanner deposed that the ordinary period was 270 to 280 days, but might be exceeded by two, three, or even four weeks. He thought there was no inconsistency in the present case (from April 15th to February 9th—that is, 301 days). He had not known any case himself in which the ordinary period had been exceeded by a week, but he had no doubt

there were such cases. He had heard of such. Mr. James F. Clarke deposed that there were cases on record extending over more than 301 days. Sir James Simpson had recorded a case of 310 days. Dr. Barnes deposed that the ordinary period was 271 days. He had known cases of 280 and of 285 days. He thought it very improbable, but did not like to say it was impossible, for gestation to extend over 301 days. It was so improbable that he did not believe it. Dr. Tyler Smith said that the longest period of excess he had known was a fortnight. Dr. Reid—a most accurate observer—had recorded forty-three cases of protraction, the longest of which was 300 days. Dr. Smith considered that case as reliable as any doubtful case could be. The verdict was for the plaintiff—damages, £200.—*Brit. Med. Journ.*, March 5, 1870.

Things not Generally Known.—The *Pharmaceutical Journal* publishes a remarkable instance of unforeseen danger arising from the facility with which oxide of silver is reduced by contact with vegetable extracts in common use. A medical man prescribed twenty-four pills, each containing two grains of the oxide of silver, a twenty-fourth of a grain of muriate of morphia, and a sufficiency of extract of gentian; the pills being coated with silver in the usual manner. The pills were delivered to the patient in an ordinary pill-box, but the lady, being in her nursery, and having no pocket in her dress, placed the box in her bosom, probably next the skin. In three-quarters of an hour a severe explosion occurred; her under-clothes were reduced to tinder, and her right breast was seriously burnt. The patient fortunately had presence of mind enough to seize the part with both hands, and thus extinguish the flame. We learn from Mr. Hills that a similar occurrence has been known in compounding the extract of colocynth with the oxide of silver, and that with creasote or oil of cloves this salt is reduced to the metallic state, with the production of heat amounting often to an explosion. In fact, many of the essential oils reduce the oxide of silver, and one of the processes for silvering glass is founded on the fact, oil of cloves being usually employed in the operation. We may mention that when glycerine and per-

manganate of potash come in contact, heat is evolved, sometimes resulting in flame. An instance has occurred in which a wound was covered with the glycerine of starch, and then sprinkled with powdered permanganate of potash, when the heat produced became unbearable.—*Lancet*, March 26th, 1870.

Kryptophanic Acid—a New Acid Existing in Urine.—Dr. THUDICUM has lately communicated to the French Academy of Science, and to the Chemical Society of London, an account of a nitrogenous constituent of urine, to which he has given the name Kryptophanic Acid. Next to urea, it forms the most abundant organic constituent of urine. Its salts are in general soluble in water and insoluble in alcohol, and advantage of the latter fact is taken in the process followed for the extraction of the acid. The formula of the free acid is $C^{10}H^{18}N^2O^{10}$. There are several sets of salts, some containing four equivalents of base, some containing three equivalents, and some with only two equivalents. The mercury salt is insoluble in water, and is thrown down along with the mercurial compound of urea in the ordinary process for the estimation of urea in urine. It will, therefore, be requisite to apply a slight correction to the results of urea-determinations in order to allow for the presence of kryptophanic acid. The process by which the new acid is obtained is, in outline, as follows. The urine, after having been treated with milk of lime, filtered and concentrated by evaporation, is slightly acidified with acetic acid, and precipitated with alcohol. The crude kryptophanate of lime is purified, and converted into lead-salt, which is decomposed with sulphuric acid.—*Brit. Med. Journ.*, April 9, 1870.

A New Test for Albumen.—Dr. C. MEYER-TROY, Joint-Lecturer on Chemistry at the London Hospital, has noted that a mixture of equal volumes of acetic and carbolic acids is a far more delicate test for the presence of albumen than any other method that has been proposed. In using this test with urine, it is necessary to shake the test-tube, as some opacity is produced by the mere admixture of fluid, which, however, disappears on agitation.—*Brit. Med. Journ.*, April 9, 1870.

CHAMBERS ON INDIGESTIONS—Enlarged Edition, Just Ready.

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AUTHOR'S PREFACE.

Since publishing my first edition, I have inserted upwards of ten dozen cases, and have rearranged, indeed in part rewritten, the commentary upon them. A third edition is not yet required in England, so I send the MS. for publication to America. I have faith in the kindly feeling with which it will be received there.

LONDON, December, 1869.

A few notices of previous editions are subjoined.

We look upon this chapter as a most valuable guide to physicians, and warning to patients concerning transgressions against the established physiological conduct of life. The advice as to medical treatment proper, is also most serviceable. It should be read by every medical man in the country, and he should read his lessons to his patients from out its pages. We only regret that we have no room for a more thorough analysis of its contents.—*N. Y. Medical Journal*, March, 1868.

The work should be in the hands of every practicing physician.—*Boston Med. and Surg. Journ.*, Nov. 21, 1867.

Apart entirely from the merits of this work, which have been so highly appreciated by the profession that a large edition has been exhausted in an unprecedentedly short time, the book is one of the most readable in medical literature; such a one, in fact, as a wearied practitioner, anxious to gain information, but too tired to take to heavy work, would be delighted to pick up in a spare half hour.—*London Med. Times and Gazette*, Nov. 23, 1867.

It is nearly as exhaustive as any work on such a complex subject can be.—*London Lancet*, March 16, 1867.

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